Welcome to Nova Vision Care

PATIENT INFORMATION

Date _____

Please circle
Mr. / Mrs. / Ms. / Dr. LAST NAME _____ FIRST _____ MI _____

Address _____City_____ State_____ Zip _____

Cell # _____ Work # _____ Home # _____ Other # _____

E-mail _____ Preferred Contact: Cell / Work / Home / Other / Text / Email

Birth Date ___ ___ / ___ ___ / ___ ___ ___ ___ □ Male □ Female Marital Status: □ Single □ Married □ Widowed □ Child

SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Driver's License# _____ Occupation_____

Employer/School _____ Guardian/Caregiver_____

In case of emergency: Name _____ Phone # _____

REFERRAL INFORMATION

How did you choose our office for your eye and vision needs?

□ I am a previous patient □ Insurance List □ Website □ Sign/Location □ Yellow Pages □ Other _____

□ Friend/Relative _____ □ Another Doctor: _____

INSURANCE INFORMATION

Primary Medical Insurance (ex: Anthem, Medicare, TriCare)

Insurance Co. _____

ID #_____

Policy/Group # _____

Policy Holder Information □ Self

If NOT self, please provide the following:

Name: _____

Patient relationship: □ Spouse □ Child □ Other

Sex: □ Male □ Female

Address: □ Same as Patient

Street _____

City/State/Zip _____

Phone Number _____

SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Birth Date ___ ___ / ___ ___ / ___ ___ ___ ___

Employer _____

Primary Vision Insurance (ex: VSP, EyeMed, Humana Vision)

Insurance Co. _____

ID #_____

Policy/Group # _____

Policy Holder Information □ Self □ Same as primary

If NOT self or same as primary, please provide the following:

Name: _____

Patient relationship: □ Spouse □ Child □ Other

Sex: □ Male □ Female

Address: □ Same as Patient

Street _____

City/State/Zip _____

Phone Number _____

SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Birth Date ___ ___ / ___ ___ / ___ ___ ___ ___

Employer _____

Please list any additional medical or vision insurance plans:

_____

_____

SIGNATURES AND OFFICE POLICIES

PRINT NAME _____ **DATE** _____

FORMS:

I, the undersigned, agree that the personal, vision, and medical history information completed or updated either electronically or on paper is, to the best of my knowledge, complete and correct.

Patient or Guardian Signature X _____

ASSIGNMENT & AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE BENEFITS

I hereby authorize direct payment of benefits to Nova Vision Care, P.L.L. for services rendered by their doctors, or under their supervision. Furthermore, I authorize Nova Vision Care, P.L.L. to release any medical or incidental information that may be necessary for processing my insurance claim.

Patient or Guardian Signature X _____

ACKNOWLEDGEMENT OF HIPAA PRIVACY POLICY

I acknowledge that I have been notified of or received a copy of Nova Vision Care's Notice of Privacy Practices. If you would like a copy of our Hipaa Privacy Policies, please notify the receptionist.

Patient or Guardian Signature X _____

OFFICE POLICIES:

Please read the following information carefully. You the patient are responsible for knowing the information below.
Please initial that you understand and agree to each of the following:

Insurance:

Our office will gladly work with you to get the maximum benefit available to you. We can make no guarantee of any estimated coverage. The policy is an agreement between you and your insurance company and, therefore, we are not responsible for problems or discrepancies. Ultimately, this must be handled by you, the insured, but we will be happy to assist you in any way that we can.

_____ I understand my copay is due at the time of service. Please note we are often considered a specialist therefore the specialist copay may apply.

_____ I understand that if Nova Vision Care, P.L.L. is a provider for my insurance, they will bill my insurance for covered services after my visit. I understand that I am responsible for all copays, deductible, coinsurance, and non-covered services.

_____ I understand that if Nova Vision Care, P.L.L. is not a provider for my insurance or I am "Self-Pay" that payment is expected in full at the time of service.

_____ I understand that I am responsible for the balance on my account for any professional services rendered.

Glasses and Contact Lenses:

_____ I understand that payment is expected in full at the time of ordering for glasses and contact lenses.

_____ I understand that notification of eyewear (glasses and/or contact lenses) readiness as well as reminders for upcoming appointments may be sent via email, text, or call.

Account Information:

_____ I understand that accounts with balances 60 days or more past due will be assessed a monthly finance charge. If regular monthly payments are not made, your account may be turned to collections.

_____ I understand that any bounced check will result in a $30 returned check fee.

Payment Options:

- Cash or Check
- Credit Card including Visa, MasterCard, Discover, and American Express
- Care Credit; Financing for Care Credit can be applied for by filling out an application in our office or online at www.carecredit.com

Please feel free to contact our office manager if you have any questions regarding the office policies.

Office Use:
□ NEW
□ ESTABLISHED
INS _____

Welcome to Nova Vision Care

PATIENT HEALTH HISTORY

DATE _____

LAST NAME _____ **FIRST** _____ **MI** _____ **DOB** _____

The information in this confidential personal history form is critical to the evaluation of your eyes and your vision.

What is the main reason for your visit today? _____

□ Blurred Vision □ Contact Lenses □ Glasses □ Vision Therapy □ Headaches □ Floaters □ Diabetic Eye Exam

□ Macular Degeneration Evaluation □ Cataract Evaluation □ Glaucoma Evaluation □ Eye irritation □ Loss of vision

Did another doctor or health care professional refer you to our office for your examination today? □ Yes □ No

If yes, please provide any known information so our doctor may write a report back to your referring doctor:

Name: _____ Office Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Please provide any known contact information about your primary care physician and pharmacy in the event our doctor may need to contact them:

Primary Care / Family Physician:

Name _____

Office Name _____

Address _____

City/State/Zip _____

Phone # _____

Pharmacy Information:

Name _____

Address _____

City/State/Zip _____

Phone # _____

When was your last eye examination? □ 1 year □ 2 years □ 3-5 years □ Never □ Other: _____

Patient Ocular History:
(Check all that apply to you, both current and past history)

□ Glasses □ Contact Lenses □ Dry Eyes
□ Floaters □ Flashes □ Vision Therapy
□ Glaucoma □ Macular Degeneration
□ Cataracts □ Retinal Detachment
□ Other: _____
□ Eye Surgery: _____
□ Eye Drops: _____

Family Ocular and Medical History:
(Check all that apply to siblings, parents, or grandparents)

□ Glaucoma □ Macular Degeneration □ Cataracts
□ Eye Turn/"Lazy Eye" □ Retinal Detachment □ Diabetes
□ High Blood Pressure □ Cancer □ Stroke
□ Other: _____

Patient Social History:

Hobbies: _____

Daily Computer Use: □ None □ 1-3 hrs □ 3-6 hrs □ 6-9 hrs □ 9+ hrs

Contact Lenses:

Do you currently wear contact lenses? □ Yes □ No

If yes, what type/brand do you currently wear? _____ □ Not Sure

How many Hours/day? _____ Do you sleep in your lenses? □ Yes □ No □ Sometimes

How often do you replace your lenses? _____ What solution do you use? _____

If no, are you interested in contact lenses? □ Yes □ No -- If yes, have you worn contact lenses before? □ Yes □ No

A contact lens evaluation and/or fitting to renew, update, or start contact lens wear is required every year to assess the fit of the contact lenses as well as ensure the health of the eyes related to contact lens wear. This is a separate service above and beyond your yearly examination and, therefore, is a separate charge and may range from $35 - $199. ALL CONTACT LENS PRESCRIPTIONS EXPIRE AFTER ONE YEAR.

Continued on reverse

PATIENT HISTORY, continued

Review of Systems: *please circle or add all conditions that apply to you, both currently and past history.*

General: None Fever Weight Loss Weight Gain Recent Trauma Fatigue Other: _____

Ear/Nose/Throat: None Sinus Pain Hearing Difficulty Dry Mouth/Throat Other: _____

Cardiovascular: None High BP Low BP Chest Pain Poor Circulation Heart Surgery Other: _____

Respiratory: None Asthma Emphysema Sleep Apnea Wheezing COPD Cancer Other: _____

Gastrointestinal: None Pain Indigestion IBS Nausea Diarrhea Constipation Cancer Other: _____

Musculoskeletal: None Arthritis Joint Pain/Stiffness Other: _____

Genitourinary: None Pregnant Nursing Cancer Frequent Urination Other: _____

Skin: None Rash Tumors Dryness Eczema Rosacea Lupus Cancer Other: _____

Neurological: None Headaches Migraines Head Injury Stroke Tumor Other: _____

Psychiatric: None Depression Anxiety Personality Changes Insomnia Other: _____

Endocrine: None Diabetes Hyperthyroid Hypothyroid Tumor Cancer Other:_____

Blood/Lymphatic: None Anemia High Cholesterol Clotting Disorder Bruising Cancer Other: _____

Allergic/Immunologic: None Seasonal Food Hepatitis HIV+ AIDS Other: _____

Medication Allergies: None Penicillin Sulfa Erythromycin Fluoroscein Dye Other: _____

Please list all medications, vitamins, and supplements you take routinely:
If you have brought a list of your medications, please provide the list to the receptionist to copy. Otherwise, please list medications below:

□ SEE LIST PROVIDED/COPIED _____

_____

_____

_____

Height: _____ ft _____ in **Weight**: _____ lbs **Have you had a Flu Shot this year?** □ Yes □ No

Tobacco:	□ Never	□ Former	□ Current Everyday	□ Current Someday
Alcohol:	□ Never	□ Occasionally	□ Daily	□ Excessively
Illegal Drugs:	□ Never	□ Marijuana	□ Cocaine	□ Narcotics
Preferred Language:	□ English		□ Spanish	□ Decline
Race:	□ American Indian or Alaska Native		□ Asian	□ Black or African American
	□ Native American or Pacific Islander		□ White	□ Decline
Ethnicity:	□ Hispanic or Latino		□ Not Hispanic or Latino	□ Decline

Additional Eye Health Screening Options

Digital Retinal Photography Screening ($27) -- A detailed image of your retina allowing your doctor to keep a permanent photographic reference of your eye health that can be reviewed for changes when your return next year. It also allows you to see what your doctor sees. With retinal photography, your doctor is able to screen for early signs of diabetes, hypertension, glaucoma, macular degeneration, and many other conditions. A retinal photograph does NOT replace a dilated eye examination but supplements it. Recommended for every patient of any age.

□ **Elect to have retinal photography screening** □ **Wish to discuss with my doctor before deciding** □ **Decline at this time**

Macular Degeneration Screening/MacuScope ($35) -- Macular degeneration is a leading cause of central vision loss in adults. We are able to provide a test that enables your doctor to identify if you are more at risk by measuring your Macular Protective Pigment Density (MPPD). Recommended for any patient 21 years or older, especially with any additional macular degeneration risk factors (family history, 55 years of age or older, smoker (current or prior), fair colored eyes or skin, infrequent use of sunglasses, woman, diabetes, high blood pressure or other cardiovascular condition, less than 6 servings of fruits and vegetables daily).

□ **Elect to have macular degeneration screening** □ **Wish to discuss with my doctor before deciding** □ **Decline at this time**